MINISTRY OF HEALTH

Central Health Services Council

STANDING MEDICAL ADVISORY COMMITTEE

Child Welfare Centres

Report of the Sub-Committee

LONDON
HER MAJESTY'S STATIONERY OFFICE
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Chairman

Sir Wilfrid Sheldon, K.C.V.O., M.D., F.R.C.P.

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Senior Lecturer in Social Medicine, Guy's Hospital Medical School and The London School of Hygiene & Tropical Medicine.

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Consultant Paediatrician, Royal Devon and Exeter Hospital.

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General Practitioner, London.

John G. Howells, Esq., M.D., M.R.C.S., L.R.C.P., D.P.M.
Consultant Psychiatrist, Ipswich and East Suffolk Hospital.

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General Practitioner, Bristol.

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Director, Department of Obstetrics, Guy's Hospital.

F. J. W. Miller Esq., M.D., F.R.C.P., D.C.H. ⌀
Consultant Paediatrician, Royal Victoria Infirmary, Newcastle-upon-Tyne.

Mrs. D. Mumford, S.R.N., S.C.M., H.V. Cert,.
Formerly Chief Nursing Officer, West Riding of Yorkshire County Council.

Mrs. Marjorie Reid, M.B., Ch.B.,
Assistant County Medical Officer of Health, Northamptonshire County Council.

Notes:— *Appointed June, 1966
⌀ Resigned May, 1966.

CONTENTS

I Preface

1. At their meeting on 10th March 1964 the Minister of Health's Standing Medical Advisory Committee for England and Wales had before them a Note by the Department inviting them to consider whether the time had come for a re-assessment of the medical functions and medical staffing of child welfare centres. The Note said, in part:

> "While it is well recognised that medical work of great value is carried out in child welfare centres, doubts are sometimes expressed whether the centres are now needed for quite the same type of medical work as they were when they were first started many years ago. It has also been said of some centres that they tend to continue traditional work rather than turn to work that is needed in the circumstances of today.
>
> The relationship of the work done at child welfare centres to that done by general practitioners and by the hospital service certainly needs fresh thought: both general practitioners and paediatricians are taking an increasing interest in the health, growth and development of normal children; and increasing numbers of children are surviving with handicaps which necessitate early detection, full assessment, treatment and follow-up".

2. The Committee decided that a Sub-Committee under the Chairmanship of Sir Wilfrid Sheldon should be set up to look into the problem and agreed at their meeting on 14th July 1964 that the terms of reference should be:

> "To review the medical functions and medical staffing of child welfare centres and to make recommendations."

3. The Joint Secretaries of the Sub-Committee were Dr. V. G. Edwards and Mr. D. U. Jackson. Meetings were attended by Dr. R. N. Chamberlain, Mr. E. L. Mayston, Surgeon Rear Admiral W. Holgate and Mr. D. E. Holloway of the Ministry of Health and Dr. P. Henderson of the Department of Education and Science.

4. The first meeting was held on 29th January 1965 and there have been 25 subsequent meetings. Written and oral evidence from professional and other bodies has been received. A list of the bodies invited to submit evidence is given in Appendix A. The Sub-Committee is grateful for their valuable assistance and also to the B.B.C. through whose courtesy members were able to see the television broadcast "Testing for Visual and Auditory Defects in Babies and Young Children" and the film "Examining the Newborn Baby".

II Clarification of Terms

5. In the course of our discussions it has become clear that we should need to clarify the meaning which in this report we attach to certain terms because in the evidence we received these were capable of varying interpretations.

CENTRE	The premises or building in which child welfare or other activities are carried out.
CLINIC	The activity or session conducted in the centre.
CHILD HEALTH CLINIC	We use this to embrace such terms as child welfare clinic, infant welfare clinic, well-baby clinic, toddler clinic.

DETECTION	The discovery of an abnormal or handicapping condition or the suspicion of its presence.
ASSESSMENT	The further investigation of a handicapping condition to determine its degree and to decide the requisite course of action.
ASCERTAINMENT	This can imply action by the Local Education Authority under section 34 of the Education Act 1944 and therefore does not appear in this Report.
CHILD HEALTH SERVICE	Paragraph 35 indicates the Sub-Committee's preference for this term in place of Child Welfare Service.

III Introduction

6. The infant welfare movement dates from the end of the last century. At that time also, the concept of home visiting, which was the forerunner of present day health visiting, was already taking shape. Voluntary agencies, culminating in the National Association for the Prevention of Infant Mortality (1912), and parallelled by comparable efforts of various municipal authorities, were steadily pushing forward the claims of infant welfare. In 1918 the Maternity and Child Welfare Act laid the foundation of the child welfare service of today.

7. The National Health Service Act, 1946, repealed the permissive provision of previous Acts and laid an express duty on local health authorities to make arrangements for the care of expectant and nursing mothers and of young children. In 1947 advice was given by the Ministry of Health to local health authorities that "arrangements for the care of mothers and young children will need to be designed . . . . in such a way as to ensure that close integration with the general medical services, and their own midwifery service, on the one hand, and with the hospital and specialist service on the other, will naturally evolve".

8. The School Health Service remained with the Ministry of Education outside the National Health Service.

9. With the introduction of the National Health Service in 1948 many people felt that a critical appraisal was needed to determine whether the child welfare clinics were meeting the contemporary need. A few years before, some national and local studies had been undertaken. A national study (1) of the first five years of life of 5,386 children born in the first week of March 1946 and drawn from all social classes, was made by a Joint Committee of the Institute of Child Health of the University of London, the Society of Medical Officers of Health and the Population Investigation Committee. It was shown that the proportion of mothers defined as being efficient in child management and care declined steeply with falling social group and increasing family size. One of the conclusions was that the social services and educational approach of the maternity and child welfare services were of primary importance in the saving of infant life.

10. "A thousand Familes in Newcastle upon Tyne" published by Spence et al. (2) in 1954 and the follow up study "Growing Up in Newcastle upon Tyne" published in 1960 by Miller et al. (3), described an investigation of 1,142 infants

born between 1st May and June 30th 1947. The frequency and extent of disease and disablement in this sample of city children were measured with a view to obtaining a better understanding of the types and incidence of illness from infective causes, and the conditions under which they occurred. It was found that two thirds of all infants were taken to a welfare clinic at least once. The mothers from good artisan homes were the most frequent attenders and the first and second children were taken more often than subsequent children. Mothers with a poor standard of care and those with large families or with illegitimate children were less likely to attend. The number of children attending, at least once, fell from 67 per cent during the first year to 10 per cent during the fifth year. There was little evidence that toddlers, as distinct from infants, were taken to welfare centres for advice.

11. From these studies the authors questioned whether in fact child welfare clinics at that time met the needs of mothers, especially with regard to children aged 1–5 years. It was thought that an annual physical examination was desirable and that these provided a useful occasion for discussion of the child's development. But there were many matters concerning the growing and developing child on which the mother required guidance. It was thought that she should be able to get such help either from a local authority child welfare clinic or from a child clinic forming part of the family doctor's practice. It was observed that if mothers were able to get the necessary advice there was little doubt they would attend such sessions more frequently and in greater numbers than they did at that time. There was little evidence that any real contact or co-operation existed between the clinics and the family doctor. Nevertheless Spence and his colleagues regarded the child welfare clinics as one of the chief agents in bringing about the remarkable decline in disease and deaths in young children in the previous half century.

12. The steady decline in the infant mortality rate has brought about a considerable change in the age distribution of deaths within the first year of life. More deaths now occur in the first week of life than in the next five years. The factors which have brought about the reduction in infant mortality and morbidity have also resulted in the saving of the lives of more young infants including those with congenital malformations and birth injuries. In consequence mentally and physically handicapping conditions including multiple handicaps, in large part due to congenital causes, are one of today's chief problems in child health.

IV Present Arrangements

Premises

13. About two thirds of the premises in which child welfare sessions are carried out are rented such as church and community halls; one fifth are purpose built premises (which may include facilities for the school health and dental services) and the rest are adapted buildings. A few local health authorities use mobile clinics and there is also a small number of health centres, at present about 40, where general medical services are provided as well as child health and other local authority services. In addition a number of general practitioners hold clinics in their own premises.

14. The number of centres increased from 5,030 in 1951 to 6,376* in 1965 (see Table 2 below). This represents one centre per 7,500 of the general population. 331 of the 1,277 purpose built premises have been built during the past 5 years.

Table 2

Number of Child Welfare Centres and Sessions Held

Year	Number of Centres	Centres per 10,000 population	Number of Sessions held
1951	5,030	1.15	262,392
1956	5,676	1.27	286,356
1961	5,985	1.30	307,548
1962	6,039	1.29	313,548
1963	6,263*	1.33	329,435
1964	6,411*	1.35	332,974
1965	6,376*	1.34	342,820

* includes ante-natal and post-natal clinics

Attendances

15. Notwithstanding the doubts which have been expressed about their value there is no doubt about the continuing, indeed growing popularity of child welfare centres. Table 3 shows that the number of children under 5 attending local health authority centres rose from 1·37 million in 1951 to 1·95 million in 1965 and as a percentage of the under 5 population from 36·8% to 47·8%. Increase in children attending has not been confined to infants; it has been spread over the three age groups—under 1 year, 1–2 years, and 2–5 years. More than three quarters of children aged under 1 and two thirds of children in their second year attend child welfare centres; for children aged 2–5 the proportion is one fifth.

Table 3

Number of Children Attending Local Health Authority Child Welfare Centres

Year	Aged under 1 at end of year		Aged 1–2 at end of year		Aged 2–5 at end of year		Total 0–5 at end of year	% of under 5 population
	Number	% of age group	Number	% of age group	Number	% of age group		
1951							1,369,043	36.8
1956	461,744	66.1	378,106	56.9	481,420	17.8	1,321,270	40.1
1961	568,565	70.7	485,373	62.1	564,142	19.4	1,618,080	44.1
1962	594,033	70.7	497,822	61.9	556,486	18.6	1,648,341	43.6
1963	622,352	72.7	527,721	62.8	560,344	18.2	1,710,417	43.9
1964	653,521	74.6	574,950	67.4	628,650	19.8	1,857,121	46.3
1965	660,346	76.7	609,417	69.6	678,468	20.7	1,948,231	47.4

16. A survey carried out during the summer of 1964 by the Institute of Community Studies (4) in twelve parliamentary constituencies in England and Wales showed that attendance at general practitioner clinics is low compared with attendance at local health authority clinics even allowing for the fact that only 20% of the doctors covered by the survey held such a clinic. This is apparent from Table 4 "which also shows that attendance at a G.P. clinic is often regarded as an addition rather than as an alternative to local authority clinics. But the fall off in attendance as children get older so apparent for the local authority clinics does not occur for the special G.P. clinics". Although the number of children in Table 4 is small the findings of the survey are consistent with the experience of members of the Sub-Committee working in general practitioner clinics.

Table 4

Proportionate attendance at clinics

	Children under 2	Children aged 2–4 years
Number of children	55	95
G.P. special clinic only	4%	8%
Local authority clinic only	74%	31%
Both G.P. and local authority	9%	4%
No Clinic	13%	57%

The effect of social class and the child's place in the family on attendances

17. Twenty years ago the use of child welfare centres varied according to the social class and the child's place in the family. We have no reason to think that the position has materially altered. In the Newcastle-upon-Tyne survey (2) it was shown that the highest percentage of attenders was among social class III (Table 5). The percentage of mothers attending from social class I and II was lower than that from social classes IV and V.

Table 5

Social class and attendance at child welfare centres, Newcastle-upon-Tyne 1947–8

	Social Class			
	I & II	III	IV	V
Attenders using centres	56	387	91	93
Others	46	154	56	53
Total	102	541	147	146
Percentage attenders in each social class ...	54.9	71.5	61.9	63.7

Different social groupings were used by Douglas and Blomfield (1) studying a cohort of children born in 1946. Their results in Table 6 show that the best attendances were made by the black-coated group, relatively few of whom failed

to take their children at least once to the centre and 18 per cent of whom took them regularly throughout the five years of the survey. A high proportion of professional and salaried groups never used the centres but when they did use them they were likely to do so regularly. Half the agricultural workers did not take their children at all, presumably owing to isolation, but the proportion of regular attenders was high among those who went.

Table 6

The use made of Child Welfare Centres by Mothers in each Social Group

Use of Centres	Non-Manual Workers		Manual Workers				Self Employed	*All Groups
	Professional and Salaried	Black-coated	Skilled	Semi-skilled	Un-skilled	Agricultural		
	%	%	%	%	%	%	%	%
Not Used	38.9	22.6	22.9	28.1	20.5	50.0	51.4	27.8
'Irregular' Use	47.1	59.3	63.6	56.4	69.7	36.8	39.3	58.6
Regular Use	14.0	18.1	13.5	15.5	9.8	13.2	9.3	13.6
All Mothers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* Adjusted for sampling.

We know of no comparable work which has been done on the social class of the mothers attending clinics since these dates. MacDonald (5) looking at the child health services in a new housing estate in Hertfordshire in 1957 attempted to do so but found it difficult as nearly three quarters of the families belonged to social class III. The only difference discovered was that a slightly higher proportion of the children of "clerical" workers belonging to social class III attended the clinics than those of "non clerical" social class III workers and other social classes.

18. The variation in attendance according to the child's place in the family is shown in the figures in Table 7 relating to the Newcastle Study (2). The first child was taken to the Welfare Centre more frequently than subsequent children and the chance of attendance diminished with each child; even so nearly 30 per cent of the first children were never taken.

Table 7

Attendances at child welfare centres, Newcastle-upon-Tyne, 1947-48 and child's place in family

	1st Child	2nd Child	3rd Child	4th and Subsequent Children
Users	310	186	80	71
Non-users	125	93	55	47
Total	435	279	135	118
Percentage in each group	71	67	59	60

Douglas and Blomfield (1) found that proportionately first-born children were taken most often to welfare centres; this was true for all social groups but the trend was most marked among unskilled manual workers. MacDonald (5) found that "at any given age children with younger brothers and sisters were more often brought to the clinic than those who had none and all children were seen less frequently at the clinic as their place in the family increased. For example, the proportion of first born children under 18 months without younger siblings who attended the clinic once a month or more was 57 per cent; that of children whose place in the family was fourth or more, 19 per cent".

Staffing

19. The staff in attendance at a local health authority child welfare centre varies according to the size of the centre but for a routine session usually consists of a medical officer, 1-2 health visitors and a food sales clerk. In some areas there may also be a clinic nurse and a voluntary worker and a clerk.

20. A special enquiry was undertaken by the Ministry of Health into medical staffing of child welfare centres in 1961. Information was received from 141 out of a total of 146 local health authorities in England and Wales and showed that a great many doctor-hours are consumed by child welfare work. A Senior Maternity and Child Welfare Medical Officer was employed in 39 authorities (Authorities with less than 250,000 population were precluded by a Whitley Council ruling from making an appointment of Senior Medical Officer). Of the Medical Officers employed full time, 117 were employed by 24 authorities and undertook only maternity and child welfare duties; 1,159 were employed by 129 authorities and combined maternity and child welfare, school health duties and other work. Of the doctors employed on a sessional basis, 876 general practitioners and 427 "other doctors" were employed by 85 local health authorities. In 12 authorities 27 general practitioners held child welfare sessions for children on their own lists in local authorities premises and in 25 authorities some 64 general practitioners held special welfare sessions in their own surgeries with a health visitor in attendance. In Gloucester C.B., Oxfordshire C.C. and Cambridgeshire C.C. general practitioners undertook practically all the child welfare work.

21. An assistant medical officer of health may be employed either full time, part-time, or on a sessional basis by a local health authority. General practitioners may be employed in several ways. They may be appointed on a sessional basis seeing not only their own patients but those of other doctors. Between 1963 and 1965 the percentage of sessions run by family doctors on behalf of the local health authority rose slightly from 17·5 to 18·7. A few authorities pay sessional fees to general practitioners who provide child welfare clinics only for the patients of their practice either in their own surgeries or in local health authority premises. In some cases the local health authorities loan the premises free of charge to the general practitioners to see their own patients, but do not make any payment. Often, the general practitioners provide these services in their surgeries without special payment.

22. Evidence has been produced showing that the volume of work, as judged by increasing attendances of children is slowly growing and it therefore seems likely that the number of doctor-hours taken up in this way will also increase. If this be so, and if general practitioners are to participate more and more in the

child welfare clinics, which is the view of the Sub-Committee, it is time that their services were put on a more uniform basis.

General Practitioner Service

23. It is customary for the medical officer in charge of the clinic to refer to the family doctor any child with a suspected defect, or thought to be requiring medical treatment. Family doctors have sometimes complained that advice given to mothers either by the health visitor or clinic doctor conflicts with the advice they themselves have given. Since the introduction of the National Health Service liaison has greatly improved, and more particularly since the schemes for the attachment of health visitors to general practice have become more widespread. Clearly the problem of conflicting medical advice will be progressively solved as more and more of the sessions at child welfare centres are undertaken by general practitioners for the children of their practice.

Attachment of health visitors

24. The traditional way of deploying health visitors is by allocating them on a geographical basis within a local authority area. In recent years attempts have been made to get closer co-operation between general practitioners and health visitors by such methods as attachments or liaison schemes. In the former, the health visitor is responsible for all the patients on the list of specified general practitioners. In the latter, the health visitor is responsible both for a geographical district and for patients on the lists of specified general practitioners; where patients live outside the health visitor's district, she does not visit them herself but is responsible for liaison with the appropriate health visitor.

25. Anderson and Draper (6) reported that 5·7% of the total of the 6,520 health visitors in England and Wales covered by their survey were attached to practices by the end of 1964. This method of working was being tried in 29 (47%) Counties and 20 (24%) County Boroughs but in only 4 Counties and 2 County Boroughs were more than 20% of the available health visitors attached. In addition to attachments, about 12% of health visitors were reported to be working in liaison schemes or were having regular meetings with general practitioners. Neither attachment nor liaison schemes were used much until 1961 but since that time they have increased rapidly. Plans for 1965 suggested that this increase would be maintained and if all of them went into operation then about 12 per cent of the health visitor population should have been working in attachments by the end of that year.

Work undertaken in child welfare clinics

26. A number of studies have been made in order to assess the type and quality of work undertaken in child welfare clinics. The results have all shown that the clinic staff are concerned with advising and re-assuring mothers, weighing children, undertaking vaccination and immunization and supplying welfare foods. The relative importance of these activities varies greatly however in the different studies. These make little specific reference to the importance of assessing the child's emotional health although in fact much of the work is concerned with this.

(*a*) In 1962, 500 mothers were interviewed at clinics throughout Cumberland. These mothers were asked why they first came to the clinic. 34 per cent

said they came for advice and reassurance, 27 per cent had been recommended to attend, 22 per cent attended to have the baby weighed, 6 per cent for injections, and 3 per cent to obtain cheap foods. It is interesting to note that 73 per cent of the mothers said they would like more group talks and discussions on topical health subjects.

(*b*) In 1962 Acheson (7) reported on the work of child welfare clinics in the borough of Southwark, in mobile clinics in Buckinghamshire, and in Rhondda, Glamorganshire. Of 245 parents surveyed, 62 per cent came for health visitor services (weighing, advice), 27 per cent for immunization, 5 per cent to see the doctor and 4 per cent for welfare foods.

(*c*) McIntosh (8) reported in 1964 on the use made by mothers of certain of the child welfare clinics in Staffordshire. In the total sample 76 per cent neither saw the doctor nor received immunization, 30 per cent of mothers only bought food, 12 per cent saw the health visitor without buying food and 34 per cent both saw the health visitor and bought food. It was found that 40 per cent of the town mothers came only to buy food compared with 15 per cent of the village mothers.

(*d*) In May 1963 an enquiry was made by the Ministry of Health into the provisions and practices of 19 child welfare centres in various parts of the country. All clinics visited had health education displays. Some centres held small group discussions while others held them in association with mothercraft classes or with mothers clubs. Welfare foods were sold in all clinics and proprietary products in all but one. During the enquiry 166 mothers were directly interviewed. Over 50 per cent of them said they were attending as a matter of routine; 18 per cent brought their infants primarily to be weighed and 12 per cent for advice on a specific problem. The remaining 20 per cent came to see the health visitor, the doctor or for some other reason.

Evidence from the Mothers

27. The Sub-Committee has not only reviewed past studies of the work done in child welfare clinics but through such agencies as the Mothers Union, the National Federation of Women's Institutes and the Institute of Medical Social Workers has obtained up to date views of the mothers who make use of the clinics. It is as well to know what the customer wants. Their appreciation of the clinics is undoubted; the need for more clinics was frequently expressed. Some indicated that they would like this service from their family doctor if he held "well baby" sessions. The great majority of mothers welcomed the opportunity to purchase infant foods at the clinics at reduced prices, but wished that there were also other distribution points such as shops or W.R.V.S. centres. There was a frequently expressed desire for more group education in health matters. Requests included appointment systems to avoid waiting; better accommodation for private discussion and for a mother to breast feed her infant and creches to take care of older children.

28. Criticism was made that some clinics were held in dingy draughty halls with insufficient heating, and that the receptacles for the babies' clothes were not always clean—factors which may have contributed to the view often expressed that babies should not be undressed for weighing. There was evidence that routine weighing has lost some of its one-time popularity. Transport problems could create difficulties in attending.

V. Is there a need for a child welfare service?

29. Statistics already presented show that attendances of children, particularly those under two years of age, at welfare clinics have continued to increase every year, as has the number of centres brought into operation. It is evident that mothers increasingly seek advice on the care and upbringing of their children over and above their care when they are sick. The Sub-Committee received ample supporting evidence of this. It seems likely that this need will increase for which there are several reasons. For example, modern medicine is enabling a growing proportion of children handicapped from birth to survive, and this often causes an added burden to the parents and is likely to give rise to considerable anxiety. A modern child welfare service will have an important role to play in assisting such parents and their child. It has been pointed out that parents of social class III form the largest clientele of the welfare clinics; as the general level of education, using this word in its broadest sense, continues to rise, and as housing and living conditions improve, so we may expect, and indeed hope, that the child welfare service will be increasingly used by those in other socio-economic groups. The growing recognition of the importance of emotional health in childhood is bound to lead to an increased use of the child welfare service. The growth of family planning is likely to increase the number of parents interested in the health of their children and more likely to take advantage of services available.

30. The Sub-Committee is in no doubt about the need both now and in the future for a child welfare service.

31. Following the introduction of a comprehensive family doctor service, doubts have been expressed whether there would continue to be a need for a child welfare service run by local health authorities. Later in this report we present our views about the increasing role that we hope the family doctor will play in the child welfare service and the conditions under which we think such development should take place. It is, however, quite certain that the number of doctors at present in general practice, their hours of service, and for some their training and their inclination, would make it impossible for general medical practice to man the child welfare service. This must be a gradual process, and meanwhile medical officers employed by the local health authority will continue to be needed. The numbers required can be expected to diminish as family doctors take an increasing share of the work.

32. The maintenance of child health in its broadest aspects involves many people of diverse occupations, with the parents playing the leading role. The doctor who wishes to exercise his professional skills in this direction will be at an advantage if in his background training he has been able to make a special study of this aspect of a doctor's work. Some of the items which should be within his repertoire of knowledge are more fully set out in paragraph 88. The proper deployment of this knowledge can only be made if he is skilled in his handling of young children and is able to transmit his knowledge and advice to the parents in a form acceptable to them and understood by them.

33. The work is preventive rather than curative. The children will be in the main healthy, and the object is to keep them so. Their numbers are amply sufficient to justify their being seen, and their parents advised, in special sessions reserved for this work.

34. Quite apart from the clinical work of the child welfare clinics, their organisation, the attachment of health visitors, and the effective deployment of the wide range of social services that are available for the well being of young children requires a highly trained medical administrator employed by the local health authority. These duties are vested in the Medical Officer of Health, where, in the opinion of the Sub-Committee, they should remain.

35. The old title of Child Welfare does not seem applicable to this concept of the work of the preventive Child Health Service of today and for this reason we prefer to talk about Child Health rather than Child Welfare. From now on in this report we shall use the words Child Health in place of Child Welfare.

36. While the clinical care of children is the responsibility of the family doctor those between 2 and 5 years are unique in having two other sources of medical care available to them. The Child Health Service concerns children from 0–5 years and the School Health Service concerns itself with children from 2 up to school leaving age. These are both local authority responsibilities and their Medical Officer of Health is usually responsible for the School Health Service. The School Health Service lies outside our terms of reference, but it has proved impossible to review the Child Health Service and to disregard the effect of our recommendations on the School Health Service. Indeed one of our objectives has been to enable the work of the two services to amalgamate as smoothly as possible. There would seem to be much to be said in favour of a unified service not only for the children in this age group but also for the whole of childhood from birth to school leaving age. Such unification would be likely to provide a more efficient service for the child, save in administrative time and in medical and health visitor staffing, and prevent duplication of services and premises. It would also simplify linkage with general practice and hospital paediatrics. We recognise the importance of direct involvement of the School Health Service in the educational organisation, but we consider that both could benefit from closer relationship with the other health services available to the child before and during school age. It is outside our terms of reference to discuss how this should be achieved, but we consider it needs further study.

VI. Functions of The Child Health Service

Routine Medical Examinations of Children presumed to be healthy

37. These have always been an important part of the work of child health clinics. Each examination should be as complete as possible and should be designed to enable the doctor to estimate the child's physical, mental and emotional development. They should coincide with the age of the child at which tests for certain specific handicaps are most suitably performed. Their spacing is therefore important, for to make them too frequently might well detract from their thoroughness and occupy doctor-hours which might be put to better use. The child's medical record card should be designed to indicate the findings at these examinations.

38. It must be pointed out that children will make additional visits to the clinics, and on some of these occasions will be seen by the doctor as well as the health visitor. For instance, schedules of immunization will make such visits necessary. It is also important that mothers should be free to visit the clinic whenever they feel the need of advice from the doctor or the health visitor.

39. Children who are known to be handicapped in any way, and those who are considered to be "At Risk" of a handicapping condition, may well require more frequent medical examinations. It is not practical to lay down how often these additional examinations should take place because they will vary from child to child, and it must be left to the doctor to decide how often he should see them.

40. The first routine medical examination at the clinic should be when the child first attends. In practice this is usually between two and six weeks of age. It is desirable that the first examination should not be later than six weeks of age. The examination at that visit should include screening tests for such conditions as congenital dislocation of the hip, talipes, spinal curvature and phenylketonuria.

41. The second routine examination should be made when the child reaches six months of age. On this occasion the first screening test for hearing should be carried out either by the doctor or by the health visitor.

42. Further routine examinations should be made at approximately each birthday up to the age of four. Although a routine examination at nine months of age is not essential, a visit at about that time should be encouraged, not only for the mother to appreciate that the staff of the clinic is maintaining interest in her child's progress, but also because this is an age when the management of a child is changing from that of an infant towards that of a toddler, giving rise to fresh problems about which many mothers will need advice.

43. At the second, third and fourth birthday examinations the cover test for squint should be undertaken; at the third and fourth birthday examinations tests of hearing should be repeated; and at the same time it is desirable that dental inspections should be carried out. At the fourth birthday examination visual acuity should be tested, if this has not previously been done.

44. Various screening tests are available to assist in early detection of handicaps and should be in routine use. We are indebted to the specialists who described these tests to us. The tests for squint, visual acuity and hearing are set out in Appendix B to this report. The record card should indicate the results of all screening tests.

45. The fourth birthday examination should be regarded as the pre-school examination, and the findings must be made available to the School Health Service. Should the doctor consider that a further examination is necessary arrangements to this end should be made. One of the purposes of the first examination undertaken by the School Health Service is to see how the child has settled down to school life, and it need not coincide with the time when the child begins schooling. It is, therefore, essential that the School Health Service should be informed of any defects discovered by the Child Health Service at the pre-school examination.

46. There is evidence that many children are starting school life with defects hitherto unrecognised or not reported. The Health of the School Child 1962/1963 (9) states that "about 14 per cent of children when they first start school are found with defects, other than dental defects, that require treatment; and of these from 20–50 per cent are not being treated . . .". "In Liverpool, for example, in 1962 of the 16,630 entrants to nursery and infant schools 1,644 had defects

that were not being treated. Many of the defects were slight, but some would have worsened without treatment and might have retarded the child's educational progress. The untreated defects included 314 children with defective vision, 158 with squint, 57 with defective hearing and 44 with discharging ears."

Infant Nutrition and Hygiene

47. Advice on infant nutrition in its broadest sense, including diet, technique of feeding and vitamins, as well as on hygiene, clothing, general child management and training has been an important function of the Child Health Service in the past. The need of mothers for this type of advice still exists, and will continue as each generation of mothers seeks education in rearing their children. This is particularly likely in the case of the inexperienced mother with her first infant, who may well find herself living in new surroundings remote from her relatives. The doctor and the health visitor in the Child Health Service must continue their roles as advisers in these matters.

48. Immigrants, especially those from developing communities, present special problems. Many have language difficulties and are accustomed to a different mode of living. Their need for practical help and advice on the problems of child management in unfamiliar circumstances is often urgent.

Detection of Defects

49. The early detection of physical, mental and emotional defects is a major function of the modern Child Health Service. Its efficient performance turns on the knowledge and training of the doctor. Although a higher proportion of such defects is likely to be found among children in the "At Risk" groups, they will also occur among those who have no known precipitating factors. The duty of the doctor undertaking child health work is to detect the defects. It may then be necessary for the child to be referred through the family doctor to a hospital specialist or assessment centre for comprehensive diagnosis and treatment.

(i) *Physical Disorders*

50. Orthopaedic defects such as congenital dislocation of the hip, talipes, scoliosis, need to be detected as early as possible and referred for treatment. With regard to congenital dislocation of the hip Barlow's (10) modification of Ortolani's test is simple and reliable. A description of it, with illustrations, has been recently published in a booklet issued by the Ministry of Health. (11)

51. Routine screening tests for phenylketonuria by the use of phenistix are being carried out at present by most local health authorities in England and Wales. We are aware that this particular test may be superseded, and that eventually detection of phenylketonuria may become part of a multiple biochemical screen, but for the time being we must concern ourselves with this test.

52. Phenistix testing may be carried out during the second week after birth, but because phenylpyruvic acid may not be detectable in the urine until the sixth week, if the earlier test is negative it should be repeated at about six weeks. The second test would thus be due when an infant first attends the child health clinic. We think that it should be the responsiblity of the Child Health Service to ensure that testing has been carried out, and to record the result.

53. It is essential that deafness should be detected as early as possible since "comprehensive hearing" develops at about six months of age. The development

of speech is dependent on constant listening, repetition and memorising of sounds. Speech habits, whether good or bad, are fixed by the age of six years and are very difficult to alter after that age. Preliminary screening tests at about the age of six months can be undertaken by the health visitor. If a hearing defect is suspected, the child should be retested by the clinic doctor or family doctor for confirmation before referral to an ear, nose and throat or paediatric department or to an assessment centre. An effort should be made to test as many children as possible; priority should be given to those "At Risk", but too much reliance should not be attached to the "At Risk" register because deafness is by no means confined to children on this register. Mothers should be encouraged to bring their children for testing. It is particularly important to observe children who are slow in developing speech. Further tests should be carried out at three years of age and before entering school, but periodic testing between six months and three years should continue if there is any doubt about hearing at the first test.

54. We have already referred to the number of untreated squints which are found in children at the first school examination. The incidence varies from one area to another and there is a tendency for the condition to run in families. It is most important to screen all children with a view to early detection and referral for treatment. The test usually applied is the cover test described in the Appendix B. The cover test can be undertaken any time after the child is able to fix light (usually within a few weeks). However, unless the child is suspected of having a squint, 18 months to two years is probably the best period for routine screening. At the same time, not all squints have developed by the age of two years and it is, therefore, advisable to repeat the test at annual birthday examinations.

55. There are several tests for visual acuity which are suitable for pre-school children and can be undertaken by a health visitor. Depending upon the intelligence of the child they could be done at about three years of age. If the cover tests have shown no abnormality it is probably unnecessary to test for visual acuity before the age of four.

56. Finally, we wish to emphasise the danger of defects being dual or even multiple, and where one is present, others should always be suspected.

(ii) *Mental Retardation*

57. Detection of retardation may be possible and indeed obvious at an early age, or it may require skilled examinations over a period of time. It calls for a knowledge of normal mental development. Emotional impairment need not go hand in hand with intellectual impairment. Formal assessment of intelligence requires the application of special tests, and falls within the province of the child psychologist or the doctor who has received special training, and may be a matter for reference to an assessment centre usually within the hospital service. The manner in which information concerning mental handicap is given to the parents may make a significant difference to their acceptance of the findings and to the child's subsequent emotional well-being.

58. At the child health clinic the parents should receive from the doctor not only help and encouragement in the handling and training of children with minor departures from normal, but also advice supplementary to that which may be given at the assessment centre. For this to happen it is necessary that the findings of the assessment centre should be made available to the doctor at the

child health clinic. It is also essential that the education authority should be informed in good time of the children within this category so that suitable educational arrangements can be put in hand.

(iii) *Emotional Health*

59. That the incidence of emotional illness in childhood is high receives support from a number of studies. The National Child Development Study of 11,000 children born in one week of 1958 had shown 10% with signs of emotional maladjustment at the age of 7. (12) Berg (13) estimated the number of families attending a child welfare clinic for emotional problems and found that there were 64 problems out of 127 children (50·4%); 18 of them were "severe" (14·2%) and 46 (36·2%) were "mild".

60. Much of the evidence presented to us states that attention should be paid to the child's emotional health; it is likely that an increasing part of the child health service will be devoted to it. The service should promote all those measures known to be conducive to emotional well-being, and should protect the child from those measures antagonistic to it. In addition it must detect signs of breakdown in emotional health at an early stage.

61. Signs of emotional ill health can appear in the first few weeks, or at any time thereafter. At each routine examination search should be made for any departure from emotional health, and any anomalies recorded. These departures manifest themselves in changes of mood, changes of behaviour, or by such physical symptoms as, for example, enuresis, tics, speech disturbance. Emotional stress in the young child stems from other individuals around the child, usually members of the family. It is in this sphere that it is particularly important to remember that the child is a member of a family unit. To promote the emotional well-being of the family promotes the well-being of the child. Equally, the early detection of emotional disturbance in the child may enable the emotional stability of the family to be restored.

62. Some emotional disturbances may respond to measures within the compass of the child health clinic, such as advice and support of the family. Others will call for referral to the general practitioner or to specialist services. Child psychiatrists are relatively few in number, and we do not consider that they should be regularly employed at child health clinics.

63. We welcome the attention given to emotional health by the general practitioner and health visitor; working together in families, surgeries and health centres, they have, jointly, a unique part to play in the detection and management of emotional illness.

Parental Counselling

64. Much has been said about the pressures and tensions in present day society, of the loneliness and isolation of some mothers, particularly in new housing estates where they have become cut off from their former friends and relatives. Doctors working in the Child Health Service require an understanding of the psychology of the family as well as of the child, and must give the time to listen to the anxieties of the parents. The child is often the person who introduces the problems of the family to the doctor. The sooner the difficulties of the family are brought to light the better the prospect of solving them.

65. There is an advantage in arranging special discussion groups for parents with handicapped children, because they particularly need help, and can benefit from the experiences of others with similar problems.

Health Education

66. Health education is an integral part of the Child Health Service, and we agree with the view expressed to us that "the child health centre today fulfills not only a medical function but an important social and educative function as well, and can almost be said to stand *in loco parentis* to many young mothers who receive help from the social contacts which they make at the centre, as well as from the health teaching, support and advice which they obtain from the trained staff".

67. Health education can be given in many ways including individual teaching, group discussion, visual aids and the distribution of appropriate literature; the loan of suitable books can often be arranged by the larger centres. Individual teaching is part of the private interview between the doctor or health visitor and the mother. Group discussions enable the mothers to realise that others have problems similar to their own. They are reassured when they find that other parents have dealt successfully with behaviour problems. They learn what to expect at different stages of development and how to deal with children who will not eat, will not sleep, have difficulties over toilet training etc. These discussions can be carried out either as part of the child health session or as part of parent's clubs. These latter also allow for tasks and discussions on topics of wider interest such as care of the handicapped, old age, family planning, accidents in the home. Care should be taken, however, to avoid didactic lectures and rigid educational attitudes as teaching needs to be broadly based and dogma avoided. Parents' clubs are best held in the late afternoon or evening to allow fathers also to participate. It may be necessary to provide a creche so that the children can be looked after; this is a field in which voluntary workers can play a useful part.

68. Posters, small exhibitions with leaflets for display can be used with advantage in clinics, the subjects chosen being seasonable, such as safe toys at Christmastide, the disposal of litter during holidays, etc. The advice and help of the health education officer should be sought on these matters, and on the provision of films, film strips and other visual aids. It is important that the services of the health education officer should be fully used. If neighbouring smaller authorities do not find it economical to employ a health education officer themselves they should whenever possible share.

Measurements

69. The recording of a child's weight has become to a great extent a ritual, although by itself it is not a valuable criterion of progress. For various reasons it is liable to error. It is inadvisable for mothers to compare the weight of their children with that of others and frequent weighing can be a source of needless anxiety. We recommend that infants should be weighed at their first attendance and at subsequent birthday attendances, although weighing at other times may be requested by the doctor or health visitor. On all these occasions the child should be undressed. The weighing can be carried out by a voluntary worker.

70. When for scientific investigation the weights of children are required, random sampling with reliable instruments used by experienced observers is thought preferable to reliance on measurements of children *en masse*.

71. Increments in height are of greater significance than gains in weight, and we recommend that height should be recorded at the various birthday examinations. We appreciate that measurement of height in the one-year old may not always be practicable, and that at that age it usually requires two people to make the measurement. There is, of course, a relationship between the height of parents, and their children, and therefore parent's heights should also, where possible, be recorded.

72. We recommend that all measurements of height and weight should be recorded in both the English and the Metric systems for which a conversion table should be part of the child health clinic equipment.

73. We debated whether other measurements, such as head circumference, should be recorded, but considered these have no valuable purpose as a routine in a child health clinic.

Immunization and vaccination

74. Vaccination against smallpox should be carried out by a doctor. We debated whether other immunization procedures could be undertaken by a nurse or health visitor. We have concluded that the decision as to a child's fitness to undergo immunization must rest entirely with the doctor. He may delegate to his nursing staff the actual task of giving the injections, but this must be carried out under his general supervision.

75. The question of special sessions being set aside for immunization procedures has been considered. We received evidence both for and against such arrangements. The numbers of children attending the clinics, and whether they are held in urban or rural areas bear on this subject. We have concluded that the question of separate sessions must be decided in the light of local circumstances.

76. It is not our duty to lay down schedules of immunization and vaccination since the choice of these is a matter for the local health authority or the family doctor to decide. However, it is important to ensure that all children, including those of problem families of whatever social class, receive immunization and vaccination. We recommend that the Medical Officer of Health in consultation with the medical staff of child health clinics, the family doctors and the health visitors, should ensure that all children in his area receive vaccination and immunization at the clinic or in the general practitioner's surgery or at home, and in particular, that suitable arrangements are made to follow up those who fail to attend.

77. Mothers are apt to forget the immunization state of their children, and for this reason many local health authorities give the mother an immunization record for each of her children. We recommend that this should become the universal practice.

Sale of Welfare and proprietary foods

78. The child welfare movement had its origins in the milk depots set up towards the end of the 19th Century to supply free or cheap prepared infant feeds. The child welfare clinics of the 20th Century continued this tradition supplying various proprietary dried milks at cost price. In cases of need it was given free or at a reduced price; alternatively tokens for liquid milk were given.

Vitamins and other food supplements were also supplied. In 1940 the Welfare Food Service started and National Dried Milk and vitamin supplements were distributed by the Ministry of Food through their food offices, child health clinics, and other distribution points. At the end of food rationing in 1954, the Welfare Food Service was transferred to the Ministry of Health and the distribution of welfare foods, other than liquid milk, was undertaken by local health authorities. In 1962 nearly 60 per cent of the National Dried Milk was distributed by child welfare clinics, and the remainder from other points such as village shops. The decision as to whether proprietary foods are sold at child health centres has been a matter for local decision, but in practice nearly all local health authorities provide this service; the range of stock, however, varies considerably.

79. We were told that some mothers come to the clinics solely to buy food, and that this was a useful service for busy mothers. Others requested that for this purpose clinics should remain open at times beyond the usual clinic hours, others asked for a wider range of distribution points.

80. We envisage the Child Health Service of the future concentrating on the maintenance of the health of infants and young children, detecting at an early stage the presence of handicaps and departures from normal health, and giving advice and counselling to parents on the manifold problems which may arise during the raising of a family. The doctors who are to do this work will require special training and experience, well in excess of what so widely obtains at the present day. The clinics of the future must carry a high reputation for the quality of their work. It is difficult to see how the sale of infant foods does anything to enhance this reputation. The Sub-Committee considers that it need no longer be a function of the child health clinic to purvey National Dried Milk, proprietary infant foods and cereals. The actual sale of foods and other preparations with the necessary book-keeping and collection of dues is certainly no part of the duties of the doctor or the nursing staff. If a local health authority wishes to continue the sale of these commodities, it is our view that this should be organised as a separate activity. Where a general practitioner holds an officially recognized child health clinic in his own premises it should not be incumbent on him to arrange for the sale of these foods.

81. The distribution of medicaments, such as iron preparations, should be discontinued.

82. The distribution of supplements of vitamins A, C and D is on a different footing, partly because their take up through other sources might prove inadequate and partly because they are retailed at a lower cost through the clinics than through other channels. The Sub-Committee therefore considers that their distribution through the clinics should continue.

VII. Medical Personnel.

83. An increasing share in the preventive health services for children is being taken by general practitioners, but traditionally the work in child health clinics has been undertaken either by full-time or part-time local health authority medical officers. Many tributes have been paid to these officers. On the other hand the nature of their work has been criticised. Thus, McKeown (14) felt

that it was "illogical to assign the preventive services for an individual—a pregnant woman, a pre-school or school child—to one doctor, and the curative services to another". Essex Cater (15) wrote that one of the major weaknesses of this type of service lay in it being "a duplication of, and confusion with, the work of family doctors". We have received evidence both from mothers and professional organisations suggesting that many general practitioners are unable to find the necessary time for preventive work. We have also received evidence that some mothers felt it unfair and unreasonable to bother a busy general practitioner with problems such as feeding or toilet training.

84. We visualise that eventually the Child Health Service will no longer be a distinct and separate entity, but will become part of a family health service provided by the family doctor in a family health centre. To attain this end various developments need to be encouraged.

(*a*) Some general practitioners, working on their own, give special sessions to running a child health service for the children in their practice, but if this work is to be performed by family doctors on a countrywide basis, the development of group practice needs to be fostered. The formation of a group would facilitate the organization of child health work within the practice and make easier the attachment of local health authority staff and thereby liaison with the local health authority.

(*b*) For the time being, where the premises of a family doctor are considered to be suited to the conduct of child health sessions (see under Accommodation paragraphs 108-115) such premises may be used for this purpose. Where the local health authority already possesses satisfactory premises, every effort should be made to accommodate in these premises the family doctors concerned with the Child Health Service. We have written above of family health centres, because we consider that child health is only one facet of family health. We see these centres as buildings which should be for the use of both the local health authority and the family doctors, in which a wide range of services, including that of child health, is offered. Purpose-built health centres are gradually increasing in number; their development should be pushed forward as speedily as is practicable.

(*c*) If the clinical side of the Child Health Service is gradually to pass into the hands of the family doctors, its efficiency will depend to a great extent on the attachment by the local health authority of health visitors to the practice of the doctor concerned. Every encouragement needs to be given to this aspect of the Child Health Service, and to the recruitment of health visitors.

85. The acceptance by family doctors of clinical responsibility for the Child Health Service at a national level must inevitably be a gradual process. Meanwhile, and for some years to come, there will be a need for medical officers of the local health authority to undertake the clinical duties required by the service. These medical officers must be specially trained for their work as must also the participating general practitioners.

86. At the present time a term of clinical duties in the Child Health Service is often undertaken as a stepping-stone towards the post of Medical Officer of Health. We consider this to be unnecessary. Whilst the Medical Officer of Health must be responsible for the administration of the Child Health Service in his area, he need not necessarily be required to undergo the postgraduate clinical training essential for the child health doctor of the future.

87. We consider that there is a potentially important place in the Child Health Service for the part-time woman doctor, provided that she has undergone the requisite postgraduate training. She would then be competent to work either as a part-time medical officer of the local health authority, or to assist in the child health work of a group practice.

Training of Child Health Doctors

88. There are certain items of knowledge which any doctor who undertakes work in a child health clinic specifically requires. This knowledge can be summarised as follows:—

(1) Anatomy, physiology and psychology of children from birth to five years of age.

(2) Infant nutrition and hygiene.

(3) The range of normal growth and development, and the recording and significance of physical and mental measurements.

(4) Ante-natal (including genetic), intra-natal and post-natal hazards which place infants at risk of handicaps.

(5) Tests for specific defects, e.g. special senses, biochemical, skeletal.

(6) The recognition of acquired illnesses, physical and emotional.

(7) An understanding of the common stresses and strains of normal family life.

(8) Sufficient knowledge of child psychiatry to recognise and advise upon early emotional disorders.

(9) Immunization and vaccination.

(10) Capacity to instruct and teach parents individually and collectively.

(11) Legislation and public administration—both statutory and voluntary.

(i) *Undergraduate training*

89. Undergraduate training cannot be expected to produce newly qualified doctors with the particular skills and specialised knowledge needed to undertake child health work. Nevertheless, if family doctors are to play an increasingly large part in the Child Health Service, the scope of the work should be introduced to undergraduates. We therefore recommend that the items of knowledge which have been enumerated in paragraph 88 should be brought to the attention of the Deans of the Undergraduate Medical Schools, and through them to the clinical teachers.

90. We are impressed with the close relationship that is so often apparent between child health and the family circumstances, and in this connection we would stress how necessary it is for undergraduate clinical teachers to emphasise the importance of the social and family background of the patients.

(ii) *Postgraduate training*

91. The doctors who, in the future, will staff the Child Health Service, whether they be general practitioners or medical officers of the local health authority will clearly need special vocational postgraduate training.

92. The Diploma of Public Health (D.P.H.) is necessary for the doctor who wishes to become a Medical Officer of Health. The curriculum is rightly not designed to give clinical training in paediatrics, and the holder of the diploma is not thereby qualified to carry out the clinical work of the Child Health Service.

93. The Diploma of Child Health of the Conjoint Board (D.C.H.) was designed to give approval to those doctors wishing to work in the Infant Welfare and School Health Services. It has, however, tended to change its original conception, and has lost its original purpose.

94. We have been informed by the Royal College of Physicians of London that various amendments are under consideration to support the claim that the Diploma will indicate competence in the care of children to the extent required by those who are to be engaged in the Child Health and School Health Services. We anticipate that the holder of the Diploma in its new form should be qualified to undertake work in the Child Health Service.

95. We think it impracticable to expect all doctors in the Child Health Service to obtain the Diploma of Child Health, for instance those who are now working in the service, some of whom have been so engaged for several years. Then there may well be doctors whose professional interest in children and child health is not really roused until they have entered general practice, and by that time it might be difficult for them to comply with the regulations that pertain to the Diploma. We have concluded that although the D.C.H. should be regarded as a satisfactory qualification for the Child Health Service, the lack of it should not debar a doctor from entering the service, *provided* that he can produce evidence of having had suitable postgraduate experience or training.

96. The Society of Medical Officers of Health in conjunction with the London School of Hygiene and Tropical Medicine has since 1964 promoted six-week courses in child development designed primarily for doctors already experienced in child health work. These courses concentrate mainly on the principles and practice required of doctors who are already holding, or likely to be appointed to, posts of special responsibility. The teachers represent a wide range of disciplines. The course organised in the autumn of 1964 involved 68 speakers representing at least 25 different aspects of child health. We think that this type of course, expanded to include instruction in the items of knowledge to which we have already drawn attention (paragraph 88), would form a satisfactory basis for postgraduate education in child health. The courses should be available in various parts of England and Wales, and we therefore recommend that the Postgraduate Deans of Medical Schools should be asked to organise suitable comprehensive courses in conjunction with Regional Hospital Boards or Boards of Governors and the Society of Medical Officers of Health. We see no need for the courses to end with an examination of traditional type, but those responsible for the courses should evolve a method of certification based on their estimate of the student's proficiency.

97. It may be found necessary for some of the courses to be spread over a longer time, taking place perhaps only on certain days each week, in order to allow those who cannot leave their work for a sustained period to undergo training.

98. We think that refresher courses, sometimes concerned with specific topics, should be made available and that the Postgraduate Deans should be informed of all such courses.

99. We expect the time to come when all doctors undertaking child health work will have had postgraduate training. We foresee that eventually the greater proportion of these doctors will be general practitioners. We hope that special vocational training for general practice will have regard to the sort of training in child health which we have outlined.

100. The need for postgraduate training in the various aspects of child care for medical officers undertaking this work has long been accepted by most local authorities. While the variety, nature and content of the courses has changed to meet new needs the general principle of secondment to such courses has remained constant in that, generally speaking, medical officers of local authorities have been put to no expense by their attendance. This we feel is right and local authorities should be encouraged to extend this practice. In addition arrangements should be made to ensure that general practitioners undertaking similar courses in the future should equally be enabled to undertake training without cost. It is likely that the length of the courses we envisage and their cost may be beyond the present allowances to general practitioners and if this proves to be the case special arrangements should be negotiated.

VIII. The Organization of the Child Health Service

101. We have already discussed in paragraphs 29-34 the need for a medical administrator to act as a co-ordinator of the Child Health Service maintaining the relevant records and ensuring that the mothers and children are offered the full use of the available services. Statutory responsibility for the care of the mother and her child rests with the local health authority and therefore this co-ordinator should be the Medical Officer of Health. Even when most of the work in child health clinics is undertaken by general practitioners working with health visitors there will continue to be a need for a medical administrative officer.

Types of child health clinics

(i) *Two tier system*

102. If, as we believe, the Child Health Service should essentially be part of general practice the question arises whether, in view of the increasing complexity of child health work, it would be advisable to organise a two tier system of clinics. This has been suggested in evidence submitted to us. At the local or subsidiary clinic only the simpler activities would be undertaken such as advice on infant hygiene and nutrition, routine physical examinations, simple screening tests and immunization procedures; at the central or major clinic doctors with special experience of child health would undertake more involved screening tests on children already suspected of defects and follow up those on the "At Risk" register. In the sense that such an arrangement would involve referral from the lesser to the greater clinics we are opposed to it. In discussing the functions of the Child Health Service we have made it clear that we regard one of the functions to be the detection of departures from normal. Those of a minor quality may well be dealt with on the spot or by reference to the family doctor. Those of a more serious nature may need considerable investigation before an assessment can be made, and the child in this category should be referred, in consultation with the family doctor, to the hospital service. Full assessment may require a team of specialists and such a team could only be efficiently or

economically based at a hospital. Thus a central or major clinic would lack the facilities of a hospital assessment centre and, except in urban areas, would lose the value of accessibility. Although the quality is bound to vary we consider that the type of work undertaken should present a fairly uniform pattern. We advise against setting up different categories of child health clinics.

(ii) *Toddler Clinics*

103. In paragraph 75 we have indicated our opinion that the decision to hold separate sessions for immunization must be made locally and according to local circumstances. This is also our opinion with regard to separate toddler clinics. They may involve mothers making two journeys to a centre when one would suffice. We consider that with the introduction of an appointment system, and with the assistance of voluntary or other workers acting as child minders at a clinic, it should be possible to carry out routine medical examinations and deal with immunization for toddlers and infants at the same session.

(iii) *Mobile centres*

104. In many rural areas the population to be served by any centre which is reasonably accessible may be too small to justify the cost of purpose built premises. The problem of premises for small populations is not capable of any easy solution. It is at present being tackled in several ways; by the use of mobile centres, by providing transport between outlying areas and more centrally located premises and by renting premises—which are often unsuitable. It is clear that opinions are divided as to the value of mobile centres but it is perhaps worth noting that those who have used them have generally found them satisfactory. These centres can, of course, be manned by family doctors if this meets local needs. We consider that it must be left to local health authorities to decide in the light of local circumstances how best to provide child health services for outlying rural areas.

(iv) *Evening clinic sessions*

105. We are not in favour of child health sessions being held in the evening when children should be in bed. But evening sessions can be valuable as a means of furthering social contacts and they may well be the only time at which the mother who goes out to work or the father is free to take part in group discussions on health education. We recognize at the same time that evening sessions impose extra demands upon the staff who conduct them. It would seem that the question of evening clinics must be decided according to local needs and the degree of flexibility in the working hours of the clinic staff.

Location

106. Complaints have been made to us about the distances which some mothers have to travel to get to the local health authority centre. We envisage clinics being held in the future mainly in health centres and in doctors' surgeries with suitable facilities. Their situation will depend upon the needs of the population which they serve. As attendances are permissive in character anything which may deter the busy mother from bringing her child to the clinic must if possible be avoided when fixing the location of new premises.

107. We have considered the suggestion that a district general hospital should have a health centre either attached to, or in close geographical relationship with it. This would bring benefits through closer liaison with the consultant

service, and where it is practicable we would be in favour of it. It must be remembered that the population to be served by a district general hospital may be of the order of 300,000—400,000 covering a very much wider area than that served by a health centre and access by public transport, especially in rural districts, may be difficult. For the area covered by each district hospital there will need to be several centres where child health clinics are held. Again it seems to us to be a matter for local decision in the light of local circumstances.

Accommodation

108. The accommodation in the newer purpose built maternity and child health centres and health centres is of a high standard but we received much criticism of local health authority rented accommodation which tends frequently to be overcrowded, underheated and dingy, if not dirty. Not only does such accommodation discourage mothers from attending the clinic but it is also, as one of our witnesses put it, "ill adapted to the high standard of skills which the doctor and health visitor can deploy". We have no doubt that local health authorities are well aware that many premises used for child health clinics are far from satisfactory; the number of new premises which they plan to build is evidence of this. We were, however, concerned to receive complaints about the occasional lack of cleanliness, e.g. in the receptacles used for babies' clothes. We realize that shortcomings in the premises themselves may not be immediately or easily overcome but we think it important that at all times proper standards of hygiene should be observed.

109. We are also aware that many general practitioners' surgeries are not suitable for child health clinics chiefly because they do not have enough room for the health visitor to do her work and for health education to be undertaken.

110. We have described in paragraphs 37–82 the functions which we see as part of the child health service. If these functions are to be efficiently performed a certain minimum standard of accommodation must be provided; it is particularly important to ensure that the doctor and health visitor have proper facilities for private consultation with parents and that adequate space is available for waiting and for group activities. We consider that these criteria would be satisfactorily met by observing the recommendations in the Ministry of Health's Local Authority Building Note 3 (Local Health Authority Clinics).

111. Premises built to this standard would be suitable for child health clinics whether undertaken by the local health authority or by the family doctor. We hope that as the number of general practitioners wishing to do child health work increases local health authorities will do all they can to meet requests for accommodation to be provided in purpose built premises. We think it important that in planning their future building programme local health authorities should have regard not only to the needs of those services for which they themselves are statutorily responsible but also keep fully in mind the advantages to be gained from general practitioners and local health authority staff working in close collaboration from the same premises.

112. We also hope that, where necessary, money will be spent on the extension or adaptation of existing local health authority premises so that they can be used by family doctors.

113. We realise that not all general practitioners will wish to conduct their practices from publicly owned premises, and in any case it is bound to be some

time before a sufficient number of multi-purpose buildings can be provided for those who do. As far as is possible we should like to see the general practitioner doing child health work from health centres or other local authority premises, but at present this would only be possible on a limited scale.

114. We can, however, see that some family doctors may prefer to hold child health sessions in their own surgeries, particularly in rural areas, and we have no wish to discourage this. At the same time it is reasonable to expect such premises to attain certain minimum standards. They must be large enough to allow the health visitor to do her work effectively and to permit of health education. They must contain adequate consulting, waiting and toilet facilities. We are aware that many general practitioners' surgeries are not suited to child health work because they fail in one or more of these respects. It seems to us inevitable that if a general practitioner wishes to undertake child health work in his own premises, and to be paid for it, the premises must first be approved for this purpose. We recommend that such approval should be subject to consultation between the Medical Officer of Health and the Local Medical Committee.

115. When approval of a doctor's premises cannot be granted, every effort should be made by the local health authority to make suitable accommodation available free of charge.

Appointment system

116. Some mothers complained of having to wait to see the doctor or the health visitor. This is something which tends to discourage attendance at the clinic. It is a problem which cannot be solved by the provision of more staff since they themselves are already in short supply but we think it could to a large extent be overcome by the use of appointments. We accept that in rural areas transport problems may make it difficult to arrange an appointment system and we recognize that such a system tends to reduce the opportunities for social contacts although not wholly preventing them.

117. We consider that the advantages of an appointment system outweigh its drawbacks and we recommend that it should be introduced wherever possible, particularly for routine medical examinations and immunization and vaccination. It must not, however, be rigid, for we think it important that mothers should feel free to attend the clinic whenever they wish to seek advice.

118. In view of the importance of the clinic in the social field particularly for new arrivals in the area and for those living on new housing estates separate sessions for group discussions should be organized whenever the introduction of an appointment system does not permit them to take place as part of a routine clinic session.

119. The introduction of an appointment system will call for more clerical assistance. We wish to stress that with an appointment system it is particularly important to have a receptionist who makes the mothers feel at home. This seems a field in which the voluntary worker could play a useful part.

Records

120. The accurate recording of a child's health and development is essential to the effective organisation of a child health service. The value of any record is increased if it is in a form which facilitates the transfer of information from one

person to another. We are of the opinion that the designing of a suitable record card which could be used on a national basis is essential.

121. A national card should not be too stereotyped as an over-rigid pattern tends quickly to become out-of-date. We favour a card which contains certain minimal basic data but leaves adequate space for additions according to local circumstances and special interests. The card should be either combined with, or in a form to permit it to be attached to, the school health service record card. It should be designed in such a way that the information can be programmed for a computer.

122. We have studied a few of the record cards in current use. Their very diversity indicates the difficulty of the problem of uniting in one form the child health and the school health record and presenting an even balance between physical, mental and emotional development.

123. The design of a national record card to meet our requirements calls for specialised knowledge and experience beyond the competence of this Sub-Committee. We recommend that the Standing Medical Advisory Committee should consider setting up a body competent to undertake the task.

124. Regardless of the type of record card used we recommend that whenever general practitioners undertake child health sessions either in the premises of the local health authority or in their own surgeries they should use the record card provided by the authority. The card should generally be kept on the premises where the child health clinic is held. If this is the doctor's surgery, arrangements will need to be made to keep the Medical Officer of Health informed of attendances and unkept appointments. This would be facilitated by the attachment of a health visitor to the doctor's practice.

125. The record card should be considered as part of the administrative machinery of the Medical Officer of Health and be available to him at any time. The general practitioners can also keep his own personal record of the child's health if he so wishes as he already does in the case of illness.

126. We are in favour of the record card containing all the essential information about the child. If this is to be done successfully those who provide the information must feel sure that their contributions will be treated in confidence; this may apply particularly in the case of information on psychiatric problems. It is therefore important to impress upon all concerned that, as with other medical records, information on child health cards must be regarded as strictly confidential and treated as such.

127. In paragraph 77 we have recommended that a mother should be supplied with a card for recording the immunization state of each of her children. Other information concerning the health of the child can also be recorded on this card if thought desirable.

Registers

128. To facilitate the earliest diagnosis of congenital and other handicapping conditions and ensure the best use of available medical and other resources it has become an increasing practice for local health authorities to maintain a system of registration. We consider there is a need for registration under four headings based upon the present system for the notification of births:

(i) healthy infants and children up to 5.

(ii) children "At Risk".

(iii) children with congenital malformations observable at birth.

(iv) children with handicapping conditions, physical, mental and emotional.

The first and last of these categories are self-explanatory. The second is built up from information given by the maternity hospitals and the domiciliary midwifery service of adverse factors which occurred during pregnancy or childbirth or in the child's family history and which might place a child "At Risk" of developing a handicap. The third is based on the Ministry of Health scheme for the notification of congenital malformations observable at birth; it excludes any abnormality which may not become apparent until later. This notification is aimed at bringing to light unexpected trends and the observation of any unusual concentration of malformations requiring epidemiological investigation.

129. After the birth has been notified to the Medical Officer of Health the particulars of the child should be entered under the appropriate heading on the register.

130. Movement within the register can take place in a number of ways. Normally the healthy child will remain in the same category until he enters school but at any time he may develop a condition which necessitates his transfer to the category of handicapped children either direct or after having been referred to the hospital assessment service. A child originally registered as "At Risk" may be found to be healthy; alternatively his handicap, possibly after referral to the assessment service, may be confirmed, in which case he will be transferred to the category of handicapped children. A malformation observed at birth may be curable or be of such a minor degree that no treatment is needed, or may give rise to serious handicap. Here again reference to the assessment service may be necessary before a decision is taken. The register of handicapped children will be built up mainly from children with congenital malformations and those "At Risk" but also, to some extent, from those who were previously healthy.

131. The School Health Service will have to make provision for children reaching school from the healthy and the handicapped categories. Children who start life registered as "At Risk" or having a congenital malformation should have been classified as healthy or placed on the register of handicapped children before school entry.

132. Registration must be the responsibility of the Medical Officer of Health. The decision to make an entry or to transfer from one category to another must be taken by a medical officer of the local authority acting on information received from a general practitioner, an assistant medical officer, a midwife or the hospital service. The doctor at the child health clinic, the family doctor and the health visitor should always be informed of the decision.

133. Proper registration should ensure that before children enter school all those who have been identified as being in need of special education or special attention will be brought to the notice of the education authority.

Relationship with other services

(i) *Voluntary help*

134. The child welfare service began as a voluntary effort. Although it is now part of the National Health Service there are still many aspects of the work in which the assistance of voluntary workers is invaluable. We are happy to pay tribute to their help and express the hope that they will continue to give freely of their time and energy. We think that they might find their efforts even more rewarding if they were given more information about the aims of the services and commend this suggestion to the attention of local health authorities.

(ii) *Maternity services*

135. In a number of areas it has been the practice of the maternity hospitals and departments to advise the local health authority about the condition of the mother and baby on discharge. Often the Medical Officer of Health receives at this time a copy of the letter sent to the family doctor. This practice should be encouraged, until eventually it becomes a universal custom, for there can be no better time to initiate co-operation between the services of the hospital, the family doctor and the local health authority than at this stage of a child's life.

136. Information of any adverse pre-natal, intra-natal or post-natal factors which might affect the well being of the child is of course essential to the family doctor. It is equally necessary that this information should go to the Medical Officer of Health; if he is to maintain an efficient "At Risk" register, and through him to the doctor and health visitor working at the child health clinics.

(iii) *The School Health Service*

137. In all but two areas at the present time, the Medical Officer of Health is also the Principal School Medical Officer. Although the staffs of the school health and the local health authorities may be completely separate, and although the School Health Service may also use separate clinic premises, it is much more usual for the staffs of the two services to be integrated and for clinic premises to be used jointly. This tendency is becoming increasingly common, and it has been the practice for many years of the Department of Education and Science and the Ministry of Health to encourage it.

138. Under the Education Act, 1944, Section 34, it is the duty of every local education authority to "ascertain" which children require special educational treatment, and in order to do so the parents of any child over the age of 2 years may be required to submit the child for examination by a medical officer of the authority. There is therefore an overlap between the available services for children aged 2–5 years, and this will apply particularly to the handicapped child.

139. The School Health Service lies outside our terms of reference, but it is clearly in the interests of the child that there should be the closest co-operation between the School Health Service and the Child Health Service, and it is within our terms to review the ways in which the Child Health Service can foster this relationship. At the administrative level, where the Medical Officer of Health, responsible for the organisation of child health clinics is also the Principal School Medical Officer, co-ordination of the two services should be facilitated, and when one machine can do the work of two there should be a possible economy in both administrative and clinical manpower. At the clinical level, in many

areas the assistant medical officer of the local health authority also acts as a school medical officer of the local education authority, and this can have obvious advantages for children in the 2–5 year age group, for the doctor performing his dual role should be able to discharge his responsibilities to both authorities on the same premises and even at the same session.

140. We have indicated elsewhere in this report our hope that more and more of the work of the child health clinics will be undertaken by family doctors. It is of course for the education authority to decide whether there is to be a place for the family doctor in the School Health Service. We can see nothing but benefit to the child from unification of the clinical work of the two services—see paragraphs 36.

(iv) *The Hospital Services*

141. It is customary for an assistant medical officer of a local health authority, who considers that a child should attend hospital, to refer the child in the first place to the family doctor. As general practitioners become more and more involved in child health work this system of referral will become less necessary.

142. This report has already drawn attention (paragraph 49) to the need for assessment clinics within the hospital service to which handicapped children discovered at the child health clinics may be referred. Although for many years assessment of individual handicaps has been undertaken at many hospitals, in the future there is likely to be an increasing number of children referred for this purpose. There is a special problem when a child has multiple handicaps, requiring co-ordination between the various departments that may be involved.

143. It has been suggested to us that there would be advantage in a local health authority specialist unit to which a family doctor could directly refer a patient from his practice and we are aware that some authorities have already set up their own assessment centres. Without wishing to detract from the value of the work done at these centres, we believe that they usually only cover a narrow spectrum of service, sometimes for one particular defect, and are unable to draw upon the full range of resources available within the hospital service. Highly trained medical personnel are best employed in hospitals where suitable equipment and ease of consultation with other specialists are available. We do not favour their being diverted to assessment centres outside hospitals. However we recognise that in some instances local health authorities have felt obliged to set up their own centres because of the shortcomings of the hospital service in this respect and we therefore recommend that hospital authorities should be invited to review their present arrangements in this field in consultation with the local health authorities and the general practitioner service.

144. Having expressed the view that assessment centres should be part of the hospital service there is little that we can say within our terms of reference about either the personnel involved or the organisation. It is however clear that the work of assessment will vary widely from child to child. One visit to hospital may be sufficient or several visits may be necessary. Only one department may be involved; but for the child with multiple handicaps several departments may be concerned and their various findings and recommendations need to be co-ordinated. The administrative machinery for this lies with the hospital, but it would seem that where the services of a consulting paediatrician are available he has a vital role to play. From the point of view of the Child Health service

(and we think of the School Health Service also) it would be advantageous if the medical, as distinct from the educational, assessment of handicapped children were canalised, as far as possible, through one member of the hospital medical staff who may often be the paediatrician.

145. The outcome of a medical assessment must be reported to the family doctor, the Child Health Service and, where appropriate, to the School Health Service. We doubt whether the importance of these communications is even to-day sufficiently realised by the various hospital departments that may be concerned with handicapped children.

146. When a final assessment is being made at hospital of the medical needs of a handicapped child, it would be an advantage if the family doctor or local authority doctor were invited to attend. It is in any event essential that the family doctor and the local authority should be informed of the recommendations made as a result of this assessment. This makes it vital for the hospital authority to maintain good liaison with them. We recognise that it is ultimately the local education authority that decides which children require special educational treatment and in what form.

147. Where it is practicable it would be desirable for the child health doctor to assist in the clinical work of a hospital paediatric or other appropriate department.

(v) *The Dental Services*

148. The condition of the teeth of pre-school children has an important bearing on their general health, and therefore must be very much the concern of the Child Health Service. In 1963, surveys in 7 areas of a total of 16,000 children showed that less than 18 per cent at the age of 5 years had no decayed, missing or filled teeth. The average number of affected teeth per child was over 5.

149. There are two aspects of dental care in young children that implicate the Child Health Service:

(a) *Dental education.* We have already indicated (paragraphs 67-68) the importance of health education, given during personal interviews with parents, during group discussions, and by means of posters, pamphlets and films. These methods should be directed to education in the care of teeth just as vigorously as to other aspects of health. The educative role of the dental auxiliary in this connection should prove of great value.

(b) *Regular dental inspections.* Inspection of the teeth of pre-school children by a dentist should be carried out at about the 3rd birthday, and again a year later. We realise that the present shortage of dentists prevents this from being universally achieved, but it is none the less a target at which to aim. The child health doctor will also inspect the teeth as part of his routine medical examination. The recognition of early dental disease is difficult for anyone who is not a dentist and this examination cannot take the place of inspection by a dentist. If the doctor discovers or suspects a defect he should refer the child immediately to a local authority or general dental practitioner.

150. In paragraph 110 we have indicated the accommodation we think necessary for holding child health clinics in purpose-built centres. We are aware

that some of these premises offer space and facilities for dental inspection and treatment of pre-school children. We see every advantage in this and hope that the need for these facilities will continue to be borne in mind whenever new premises are planned.

(vi) *The General Medical Services*

151. Throughout this report it is manifestly our intention to promote in every way the active participation of the family doctor in the conduct of the Child Health Service. We have thought it more appropriate that this relationship should be considered under the various sub-titles that make up this report rather than to collect under one heading the several items that bear on this subject. It is clear that if general practitioners are to play the part we envisage in the Child Health Service of the future, and must undergo special postgraduate training for this purpose, the question of their remuneration arises. This is outside our terms of reference but we think that negotiations on this subject by the appropriate bodies will be necessary.

IX. Summary of Recommendations

General

1. We are in no doubt about the continuing need for a preventive service to safeguard the health of children. We consider it would be more appropriate to describe it as a Child Health Service than as a Child Welfare Service. It is our view that in the long term it will be part of a family health service provided by family doctors working in groups from purpose built family health centres. It is within this concept that our recommendations are made.

The Functions of the Child Health Service

Routine medical examinations

2. These should be made when the infant first attends the clinic, again at six months of age, and at about the time of each birthday until the fourth. The fourth-birthday examination should be regarded as the pre-school examination unless the doctor considers that for this purpose a later examination is necessary. The routine examinations will coincide with various tests for specific handicaps. (Paragraphs 37-45).

Advice on infant nutrition and hygiene

3. The doctor and the health visitor must continue to act as advisers in these matters. (Paragraphs 47-48).

Detection of defects

4. The early detection of physical, mental and emotional defects is a major duty of the child health doctor. More comprehensive assessment is a matter for referral through the family doctor to the hospital service. (Paragraph 49).

5. Special tests must be made for specific physical disorders. Whenever one defect is present others should always be suspected (paragraphs 50-56).

6. Following detection of mental retardation parents should receive help from the doctor at the clinic (paragraphs 57-58).

7. The doctor and the health visitor have a unique part to play in the detection and management of emotional illness but child psychiatrists should not be regularly employed in child health clinics (paragraphs 59-63).

Parent Counselling

8. Doctors working in the Child Health Service require an understanding of the psychology of the family as well as of the child and must give the time to listen to the anxieties of parents. There is advantage in arranging special discussion groups for parents with handicapped children (paragraphs 64-65).

Health Education

9. Health education is so important a part of the Child Health Service that every effort should be made to develop it. To this end the health education officer should be fully used. If authorities do not find it economical to employ such an officer themselves they should share whenever possible (paragraphs 66-68).

Measurements

10. The child should be weighed, undressed, at first attendance at the clinic and at subsequent birthday examinations. At these examinations heights should also be recorded. The heights of parents should be noted whenever possible. Measurements should be recorded in the English and Metric systems and a conversion table should be part of the clinic equipment. Other measurements are not necessary as a routine (paragraphs 69-73).

Immunization and Vaccination

11. Schedules of immunization and vaccination and whether to set aside special sessions for these procedures are matters to be settled in the light of local circumstances. The Medical Officer of Health should ensure that all children in his area receive immunization and vaccination and in particular that suitable arrangements are made to follow up those who fail to attend. The practice of some local health authorities in issuing to a mother cards for recording the immunization state of each of her children should be encouraged (paragraphs 74-77).

Welfare and proprietary foods

12. National Dried Milk and proprietary infant foods and cereals need not be purveyed at child health clinics. If the local health authority wishes to continue to make these commodities available this should be organized as a separate activity (paragraph 80).

13. The distribution of medicaments should be discontinued (paragraph 81).

14. The distribution of supplements of Vitamins A, C & D should continue (paragraph 82).

Medical Personnel

General

15. In order to further the development of the Child Health Service along the lines we envisage, the formation of groups of family doctors, the building of health centres and the attachment of health visitors to general practice should be encouraged (paragraphs 83-84).

16. The need for medical officers of the local health authority in the Child Health Service will continue for some years to come. They—and general practitioners—must undergo special training (paragraph 85).

17. There is a potentially valuable role for the part-time woman doctor in the Child Health Service whether with the local authority or in general practice (paragraph 87).

Undergraduate training

18. The items of knowledge which the doctor working in the Child Health Service requires should be brought to the attention of the Deans of Undergraduate Medical Schools and through them to the clinical teachers who should emphasize the importance of the social and family background of the patients (paragraphs 88-90).

Postgraduate training

19. The child health doctor also needs special vocational postgraduate training. We anticipate that the holders of the Diploma of Child Health in the new form it is expected to take should be qualified to undertake this work (paragraphs 91–95).

20. The Postgraduate Deans of Medical Schools should be asked to organize comprehensive courses, spread, if necessary, over a period, in conjunction with Regional Hospital Boards or Boards of Governors and the Society of Medical Officers of Health. The courses need not end with an examination but a system of certification should be evolved based on an estimate of the student's proficiency. Refresher courses should also be made available (paragraphs 96–98).

21. General practitioners, as well as local authority medical officers, should be enabled to undertake postgraduate training without cost to them (paragraph 100).

The Organization of the Child Health Service

General

22. The organization of the Child Health Service calls for a highly trained medical administrator. This duty should remain as at present with the Medical Officer of Health (paragraph 101).

Type of child health clinics

23. We advise against the setting up of different categories of child health clinics. We consider that the type of work carried out should present a fairly uniform pattern (paragraph 102).

24. Toddler clinics, the use of mobile centres and evening clinic sessions are matters to be decided in the light of local circumstances (paragraphs 103–105).

Location

25. Premises must be sited according to the needs of the population they are intended to serve (paragraphs 106–107).

Accommodation

26. Premises whether provided by the local health authority or the general practitioner must be adequate for the needs of the Child Health Service (paragraphs 108–110).

27. In planning their future building programmes local health authorities should keep fully in mind the desirability of integration with the general practitioner service (paragraphs 111–113).

28. Where family doctors wish to undertake child health work on their own premises and be paid for it the premises should provide adequate facilities for the health visitor and the other activities of a child health clinic. To this end they should be approved by the Local Medical Committee (paragraph 114).

Appointment system

29. An Appointment system with proper clerical and reception arrangements should be introduced wherever possible (paragraphs 116–119).

Records

30. A National Record Form for use at child health clinics is required. We recommend that the Standing Medical Advisory Committee should take such steps as are considered necessary for the production of such a form (paragraph 123).

31. Family doctors undertaking child health sessions should use the record card provided by the local health authority. The card should be part of the authority's administrative machinery and the information on it should be treated as confidential (paragraphs 124–126).

Registers

32. The Medical Officer of Health should maintain a system of registration under four headings—healthy children, children "At Risk", children with congenital malformations observable at birth and children with handicapping conditions (paragraphs 128–133).

Relationship with other services

(i) *Voluntary help*

33. Voluntary workers give invaluable assistance. This might be enhanced if they were given more information about the aims of the service (paragraph 134).

(ii) *Maternity Services*

34. The Medical Officer of Health and the family doctor should be informed about the condition of the mother and baby on discharge from hospital and about any factors which might affect the well-being of the child (paragraphs 135–136)

(iii) *School Health Service*

35. There should be the closest co-operation at both the administrative and the clinical level between the Child Health Service and the School Health Service (paragraphs 137–140). The School Health Service must be informed of

the findings of the fourth birthday examination and of any defects discovered (paragraph 45). There would seem to be much to be said in favour of having a unified health service for children from birth to school leaving age (paragraph 36).

(iv) *Hospital Services*

36. The establishment by local health authorities of assessment centres for handicapped children should not be encouraged but hospital authorities should be invited to review their present arrangements in this field in consultation with local health authorities and the general practitioner service (paragraph 143).

(v) *Dental Services*

37. Education in dental care is an important part of health education in general and must be pursued as vigorously as other aspects of child health. Regular dental inspections should be carried out at about the third and fourth birthdays. (paragraphs 148–150).

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Appendix A

The following organizations were invited to give evidence:

British Association of Otolaryngologists
British Medical Association
British Orthopaedic Association
British Paediatric Association
Central Council of Health Education
Council for the Training of Health Visitors
College of General Practitioners
Faculty of Ophthalmologists
Family Service Units
Health Visitors Association
Institute of Medical Social Workers
Medical Practitioners Union
Medical Womens Federation
Mother Care of Children in Hospital
Mothers Union
National Council of Women of Great Britain
National Association for Mental Health
National Association for Maternal and Child Welfare
National Federation of Women's Institutes
National Union of Townswomen's Guilds
Nursery Schools Association
Queen's Institute of District Nursing
Royal College of Midwives
Royal College of Nursing
Royal College of Physicians of London
Royal Medico-Psychological Association
Society of Medical Officers of Health
Women's Royal Voluntary Service

Oral evidence was given by:

British Association of Otolaryngologists (Mr. G. Livingstone and Mr. D. Ranger)

British Dental Association (Mr. J. N. Peacock and Mr. S. R. Bragg)

Faculty of Ophthalmologists (Mr. T. K. Lyle and Mr. K. Wybar)

National Association for Mental Health (Professor O. H. Wolff, Dr. J. H. Khan and Miss M. Appleby)

National College of Teachers of the Deaf (Miss N. North, Mr. R. Marshall, Miss N. Meredith and Mr. M. Reed)

Miss E. E. Wilkie, Chief Professional Adviser to the Council for the Training of Health Visitors

In addition the Sub-Committee considered letters invited from

Dr. J. B. Tilley, County Medical Officer of Health, Northumberland and Dr. A. R. Margetts, County Medical Officer of Health, Nottinghamshire, (the latter covering a memorandum by Dr. T. A. Ratcliffe, Director of the Nottinghamshire County Council Child Guidance Clinic)

Appendix B

Routine screening tests suggested for the detection of squint, impaired visual acuity and deafness

1. *Squint*

The early detection of a squint is important in order to obtain normal visual acuity in each eye and to achieve binocular single vision, and not merely to obtain a satisfactory cosmetic result.

The Cover Test consists of covering each eye in turn with the hand (or an opaque disc) during the fixation of the other eye on a target which readily attracts visual attention even in a very young child. This may be simply a spot of light from a pencil torch or even the finger of the examiner, but in the detection of a squint which is the result of an excessive accommodative effort it may be necessary to use a target, like a small picture of an animal on a short stick, which excites the act of accommodation. The target should be at a distance of about 1/3 metre from the eye so that it is essentially a test for the presence of a squint on near fixation.

The uncovered eye must be observed carefully to see if it makes any movement to take up fixation.

The cover test is also of value in detecting a latent squint, that is, a squint which is normally held in check by the strength of the binocular reflexes but which becomes converted into a manifest squint when these reflexes are disrupted by the dissociating effects of the cover test. The latent nature of the squint can be demonstrated by rapidly changing the cover from one eye to the other, and then by carefully observing the movement of the previously covered eye to take up fixation after the complete removal of the cover from both eyes.

The cover test has certain merits. It calls for no apparatus except for a fixation target which may even be the finger of the examiner. It requires a relatively small amount of experience in order to detect the presence of a manifest or latent squint. It needs only a short period of co-operation by the child and the ability of the child to fix a light, so that it is capable of being carried out after the first few weeks of life.

2. *Visual Acuity*

To test distant visual acuity the ideal method for a child who is able to read letters is a Snellen's test type chart which consists of letters of different sizes depicted on a card with a gradual reduction in size from above down. The normal level of vision is 6/6. If the vision is less than 1/60 a test is made for the ability to count fingers at different distances, or failing that for the ability to appreciate movements of the hand, or failing that for the ability to have perception of light. When this is absent the eye is blind.

In testing the vision of the young child who is unable to read letters a suitable method is to use the 'E' test. This is carried out with a cube which has different sized letter 'E's on each side; the examiner stands at a distance of 6 metres from the child and holds the cube in his hand so that one E is displayed at a time, starting with the largest and gradually working down to the smallest,

the child being instructed to hold a cut-out wooden (or plastic) E in his hand in such a way that the E is pointing in the same direction as the E on the examiner's cube.

It is, of course, essential to test the visual acuity of each eye separately. It is important, therefore to occlude each eye in turn during the test and this must be carried out carefully because there is a natural tendency for the child to peep round an occluder which is held over the eye by himself.

It must be remembered, that in both these tests some children attempt to secure a correct answer simply by guesswork and the test must be carried out in a sufficiently varied way to eliminate this possible error.

In a test for a measurement of the near visual acuity a recording is made of the ability to read words composed of letters of different sizes at the normal reading distance. Jaeger's types represent a series of different sizes of printer's types, but the more modern N types represent a more accurate series.

3. *Hearing*

Tests to detect hearing loss are relatively simple, as is the apparatus required. The room, if not sound proof, should be free of extraneous noise, and the sounds used should be quiet, made at a distance of 2–3 feet from the child, out of his sight but not directly behind his head. The co-operation of two experienced people (not counting the mother who will probably be present) is required to perform hearing tests at the ages in question.

The young child may respond to sound by looking up and appearing to be listening; by turning in the direction of the sound; by looking directly at the source of the sound. The last reaction is necessary for the child to pass the test. It is of course appreciated that an imperfect response may be due to causes other than deafness or to mental retardation.

The types of sound appropriate to different ages are indicated below:

Spoon moving on a cup rim Crinkling of tissue paper Spoon moving against the bottom of a cup	7–9 months
High pitched rattle Low pitched rattle Name said at 6 inches Singing quietly at 6 inches sss ppp ttt kkk	10–15 months
Simple sentence "Put one on top" "Give it to mummy" Singing at 12 feet Name at 20 feet Xylophone or musical box s, c, p, k, very quietly	16–30 months

Up to 5 years: conversation with a picture book.

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